

# CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: January 17, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Debride OC lat talus left, osteochondral graft left knee, excision avulsed bone left medial malleolus lateral ankle ligament reconstruction left possible osteotomy left tibia (28120, 20902, 28120, 27698, 27705)

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

04/05/12: Evaluation  
07/12/12: Re-Evaluation  
08/28/12: MRI Left Lower Extremity  
09/06/12: Re-Evaluation  
09/27/12: UR performed by MD  
11/13/12: UR performed by MD

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured when she stepped on a rock and rolled her ankle. She had x-rays and was placed on crutches and given a gel splint. She was followed by Dr. who ordered a MRI. She was then placed in a boot which she wore for eight weeks, followed by a lace-up brace for four weeks. She also underwent 11 physical therapy sessions.

On April 5, 2012, the claimant was evaluated by MD for left ankle pain which was rated 3/10. It was reported that she currently wore an ankle sleeve. She was working at a plasma center in which her job required part standing and part desk work. She still had complaints of swelling, bruising, tenderness and instability after a full day of work. On physical examination the left ankle was mildly swollen. There was some tenderness over the distal malleolus and mild tenderness over the anteromedial ankle. No lateral tenderness was noted. No gross instability with inversion stress testing. Ankle dorsiflexion was 5 degrees, plantarflexion was 45 degrees, 15 degrees of inversion and 10 degrees of eversion. Motor strength was 4+/5. Upon standing, the alignment in the left ankle was within normal limits. Dr. reported he reviewed the MRI: The patient has a lateral talar dome osteochondral injury with edema in the talus. No obvious cartilage defect or loose body is noted. She has a fair amount of swelling around the posterior facet of the subtalar joint suggesting inflammation in this area. There is what appears to be an interosseous lipoma in the calcaneus and some thickening of the anterior talofibular ligament and calcaneofibular ligaments consistent with a previous sprain. Diagnosis: 1. Left ankle sprain. 2. Avulsion of the medial malleolus. 3. Osteochondral defect of the left lateral talar dome. 4. Inflammatory change around the subtalar joint. Plan: Watch and give it time. If pain persists, repeat MRI. Three standing view of the left ankle should be taken upon return.

On July 12, 2012, the claimant was re-evaluated by for continued swelling and pain about 90% of the time. On physical examination there was mild swelling in the left ankle. She had some guarding with inversion stress testing. Her ankle ROM was 5 degrees of dorsiflexion, 50 degrees of plantarflexion, 15 degrees of inversion and 10 degrees of eversion. Motor strength with plantarflexion and dorsiflexion was 5/5, but with inversion/eversion 4+/5. X-rays performed that day (3 views) showed good alignment of the left ankle, good cartilage space maintenance, but a shadow in the lateral talar dome consistent with an osteochondral defect. Plan: Repeat MRI.

On August 28, 2012, MRI of the left ankle, interpreted by MD. Impression: 1. The lateral talar dome shows a new 5 mm subchondral cyst in the area of previously seen edema. Mild adjacent bone marrow edema remains. No large cartilage defect is visible. No joint effusion. 2. Posterior subtalar joint effusion remains. No subtalar degenerative changes. 3. Persistent mild chronic type thickening of the anterior talofibular and calcaneofibular ligament. Syndesmosis intact.

On September 6, 2012, the claimant was re-evaluated by MD for continued pain in the left ankle, most prominent at the inferior aspect of the medial malleolus. On

physical examination she had tenderness at the inferior aspect of the medial malleolus. She also had some inversion instability and some tenderness in the anterior talofibular ligament region. There was no crepitus with range of motion. Her range of motion was 5 degrees of dorsiflexion to 60 degrees of plantarflexion, 15 degrees of inversion and 10 degrees of eversion. She had good motor strength with dorsiflexion and plantarflexion and a fair motor strength with inversion and eversion of the left ankle. Dr. read the MRI from 08/28/12 as: Review of the MRI shows a 5mm osteochondral defect with a cyst in the lateral talar dome. She has an avulsion of the medial malleolus which is visible on the coronal sections and some thickening of the anterior talofibular and calcaneofibular ligaments. There is some effusion in the subtalar joint, both anterior and posterior to the posterior facet. Diagnosis: 1. Persistent pain, left ankle following an ankle sprain. 2. Lateral talar dome osteochondral defect. 3. Avulsion fracture of the medial malleolus. Plan: Conservative treatment would be in the form of continued use of an ASO, Thera-Band exercises, and activity modification. Dr. recommended an OATS procedure in addition to removing an avulsed bone fragment of the medial malleolus, and inspecting and possibly repairing the lateral ankle ligament as the claimant is very active.

On September 27, 2012, MD performed a UR. Rationale for Denial: The Official Disability Guidelines state that osteochondral autologous transfers are not recommended in the ankle and osteotomy is recommended for treatment for an ankle varus deformity. The lateral ligament reconstruction is recommended for chronic instability or acute sprain/strain inversion injury for complaints of chronic instability of the ankle with objective findings of a positive anterior drawer plus imaging studies consisting of positive stress x-rays identifying motion in the ankle or subtalar joint with at least 15 degrees lateral opening at the joint or demonstrates subtalar movement and negative to minimal arthritic joint changes on x-rays. Wheeler's Textbook of Orthopedics recommends a distal tibial osteotomy when the TAS angle is less than 80 degrees, and the patient is symptomatic despite non operative treatment. As the official MRI report of 08/28/12 read by Dr. Metzler and the requesting physician's reading of the MRI are inconsistent and are not corroborated by physical exam findings, the request for a debridement of an OC lateral talus left, osteochondral graft left knee, excision avulsed bone left medial malleolus, lateral ankle ligament reconstruction left, possible osteotomy left tibia cannot be established.

On November 13, 2012, MD performed a UR. Rationale for Denial: This request has been previously reviewed and denied due to lack of corroborating imaging by physical examination findings. The clinical submitted with this appeal request did not address this issue. Based on the clinical information submitted for review, the MRI report dated 08/28/12 is not corroborated by physical exam findings submitted from the office note of 09/06/12. There are no stress x-rays submitted identifying motion in the ankle or subtalar joint with at least 15 degrees of lateral opening at the joint or demonstrating subtalar movement. As such, the request for a debridement of an OC lateral talus left, osteochondral graft left knee,

excision avulsed bone left medial malleolus, lateral ankle ligament reconstruction left, possible osteotomy left tibia is not medically indicated at this time.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The previous adverse determinations are upheld. The Official Disability Guidelines does not recommend the OATS procedure for the ankle. There was no x-ray or exam evidence of significant instability, no indication for medial or lateral ligament repair, or resection of medial malleolus fragment. Based on review of the medical records provided and the ODG, the request for Debride OC lat talus left, osteochondral graft left knee, excision avulsed bone left medial malleolus lateral ankle ligament reconstruction left possible osteotomy left tibia (28120, 20902, 28120, 27698, 27705) is not found to be medically necessary.

**PER ODG:**

<p>Surgery for ankle sprains</p>	<p>Recommended as indicated below for Grade III<sup>1</sup> sprains. Operative treatment for severe ruptures of the lateral ankle ligaments leads to better results than functional treatment, and functional treatment leads to better results than cast immobilization for six weeks. (<a href="#">Pijnenburg, 2000</a>) There was some evidence for a lower incidence of long-term ankle swelling in surgically treated patients. However, as well as tending to take longer to resume normal activities, including work, there was some limited evidence from a few trials for a higher incidence of ankle stiffness, impaired ankle mobility and complications in the surgical treatment group. (<a href="#">Kerhoffs, 2002</a>) In view of the low quality methodology of almost all the studies, this review does not provide sufficient evidence to support any specific surgical intervention for chronic ankle instability. After surgical reconstruction for chronic lateral ankle instability, early functional rehabilitation was shown to be superior to six weeks immobilization regarding time to return to work and sports. (<a href="#">de Vries-Cochrane, 2006</a>) This RCT concluded that, in terms of recovery of the preinjury activity level, the long-term results of surgical treatment of acute lateral ligament rupture of the ankle correspond with those of functional treatment. Although surgery appeared to decrease the prevalence of reinjury of the lateral ligaments, there may be an increased risk for the subsequent development of osteoarthritis. (<a href="#">Pihlajamäki, 2010</a>) According to this systematic review of treatment for ankle sprains, there is a role for surgical intervention in severe acute and chronic ankle injuries, but the evidence is limited. (<a href="#">Seah, 2011</a>) In comparing immobilization, functional treatment and surgical treatment, the evidence does not endorse the choice of surgical over conservative treatment (or vice versa) following acute ankle sprain. With respect to secondary outcomes, the results suggest a possible positive effect of surgery on objectively measured instability (radiographical assessment of talar tilt or anterior drawer test), but complications were generally higher in the surgical group. (<a href="#">Kamper, 2012</a>) Functional treatment is preferred over surgical therapy for lateral ankle injury, but surgical treatment can be considered on an individual basis. (<a href="#">Kerhoffs, 2012</a>) See also <a href="#">Lateral ligament ankle reconstruction</a>.</p> <p><b>ODG Indications for Surgery™ -- Lateral ligament ankle reconstruction:</b>  <b>Criteria</b> for lateral ligament ankle reconstruction for chronic instability or acute sprain/strain inversion injury:  <b>1. Conservative Care:</b> Physical Therapy (Immobilization with support cast or ankle brace &amp; Rehab program). For either of the above, time frame will be variable with severity of trauma. PLUS  <b>2. Subjective Clinical Findings:</b> For chronic: Instability of the ankle. Supportive</p>
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	<p>findings: Complaint of swelling. For acute: Description of an inversion. AND/OR Hyperextension injury, ecchymosis, swelling. PLUS</p> <p><b>3. Objective Clinical Findings:</b> For chronic: Positive anterior drawer. For acute: Grade-3 injury (lateral injury). [Ankle sprains can range from stretching (Grade I) to partial rupture (Grade II) to complete rupture of the ligament (Grade III).<sup>1</sup> (<a href="#">Litt, 1992</a>)] AND/OR Osteochondral fragment. AND/OR Medial incompetence. AND Positive anterior drawer. PLUS</p> <p><b>4. Imaging Clinical Findings:</b> Positive stress x-rays identifying motion at ankle or subtalar joint. At least 15 degree lateral opening at the ankle joint. OR Demonstrable subtalar movement. AND Negative to minimal arthritic joint changes on x-ray.</p> <p><b>Procedures Not supported:</b> Use of prosthetic ligaments, plastic implants, calcaneus osteotomies.</p> <p>(<a href="#">Washington, 2002</a>) (<a href="#">Schmidt, 2004</a>) (<a href="#">Hintermann, 2003</a>)</p> <p>For average hospital LOS if criteria are met, see <a href="#">Hospital length of stay</a> (LOS).</p>
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<p>Lateral ligament ankle reconstruction (surgery)</p>	<p>Recommended as indicated below. This RCT concluded that, in terms of recovery of the preinjury activity level, the long-term results of surgical treatment of acute lateral ligament rupture of the ankle correspond with those of functional treatment. Although surgery appeared to decrease the prevalence of reinjury of the lateral ligaments, there may be an increased risk for the subsequent development of osteoarthritis. Surgical treatment comprised suture repair of the injured ligament(s) within the first week after injury, and a below-the-knee plaster cast was worn for six weeks with full weightbearing. Functional treatment consisted of the use of an Aircast ankle brace for three weeks. (<a href="#">Pihlajamäki, 2010</a>) According to a Cochrane review, there is insufficient evidence to support any one surgical intervention over another surgical intervention for chronic ankle instability, but it is likely that there are limitations to the use of dynamic tenodesis. (<a href="#">de Vries, 2011</a>) Functional treatment is preferred over surgical therapy for lateral ankle injury, but surgical treatment can be considered on an individual basis. (<a href="#">Kerkhoffs, 2012</a>) See also <a href="#">Surgery for ankle sprains</a>; &amp; <a href="#">Allograft for ankle reconstruction</a>.</p> <p><b>ODG Indications for Surgery™ -- Lateral ligament ankle reconstruction:</b></p> <p><b>Criteria</b> for lateral ligament ankle reconstruction for chronic instability or acute sprain/strain inversion injury:</p> <p><b>1. Conservative Care:</b> Physical Therapy (Immobilization with support cast or ankle brace &amp; Rehab program). For either of the above, time frame will be variable with severity of trauma. PLUS</p> <p><b>2. Subjective Clinical Findings:</b> For chronic: Instability of the ankle. Supportive findings: Complaint of swelling. For acute: Description of an inversion. AND/OR Hyperextension injury, ecchymosis, swelling. PLUS</p> <p><b>3. Objective Clinical Findings:</b> For chronic: Positive anterior drawer. For acute: Grade-3 injury (lateral injury). [Ankle sprains can range from stretching (Grade I) to partial rupture (Grade II) to complete rupture of the ligament (Grade III).<sup>1</sup> (<a href="#">Litt, 1992</a>)] AND/OR Osteochondral fragment. AND/OR Medial incompetence. AND Positive anterior drawer. PLUS</p> <p><b>4. Imaging Clinical Findings:</b> Positive stress x-rays (performed by a physician) identifying motion at ankle or subtalar joint. At least 15 degree lateral opening at the ankle joint. OR Demonstrable subtalar movement. AND Negative to minimal arthritic joint changes on x-ray.</p> <p><b>Procedures Not supported:</b> Use of prosthetic ligaments, plastic implants, calcaneus osteotomies.</p> <p>(<a href="#">Washington, 2002</a>) (<a href="#">Schmidt, 2004</a>) (<a href="#">Hintermann, 2003</a>)</p> <p>For average hospital LOS if criteria are met, see <a href="#">Hospital length of stay</a> (LOS).</p>
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Osteochondral autologous transfer system (OATS)	Not recommended in the ankle. While osteochondral autografting has been principally performed on the knee, the OATS technique may have promise in the ankle. Although the OATS procedure is generally reserved for salvage of failed debridement and drilling in the ankle, it may have applications in primary surgical management, but long-term outcome of the OATS procedure is not yet available. ( <a href="#">Easley, 2003</a> ) Further sufficiently powered, randomized clinical trials with uniform methodology and validated outcome measures should be initiated to compare the outcome of osteochondral transplantation (OATS). ( <a href="#">Zengerink, 2010</a> ) See the <a href="#">Knee Chapter</a> , where Osteochondral autograft transplant system (OATS) is recommended.
Osteotomy	Recommended for hallux valgus. Surgical osteotomy appears to be an effective treatment for painful hallux valgus. ( <a href="#">Torkki-JAMA, 2001</a> ) See also <a href="#">Surgery for hallux valgus</a> .

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**